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Statistical Bulletin

METROPOLITAN LIFE INSURANCE COMPANY

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Longevity at Record High in Industrial Population

THE expectation of life at birth, as determined from the mortality prevailing in 1945 (excluding deaths from enemy action), reached an all-time high of 64.95 years among the millions of Industrial policyholders of the Metropolitan Life Insurance Company. This figure is one half year greater than that for 1944, and 1½ years above that for 1941, our last prewar year. In fact, each of the war years made a better record than any year before the war. Comparisons with earlier years give astounding gains—almost 4¾ years in the last decade, nearly 9½ years in the past two decades, and 18⅓ years in the third of a century that the Company's Welfare program for policyholders has been in operation. The details appear in Table 1 on page 2.

The extraordinarily good record for the war years was achieved despite many adverse conditions. The very large number of insured men called to the colors were exposed to the special risks which, quite aside from enemy action, are incidental to military life—more particularly accidents. The civilian population suffered hardships and dislocations. Millions of people migrated to war production centers, worked long hours at unaccustomed tasks, and lived in overcrowded quarters. Yet in the face of these difficult circumstances a record was established by our industrial population. Two factors have contributed materially toward bringing about this favorable experience: the generally raised standard of living resulting from full employment at relatively high wages; and the widespread use of sulfa drugs and penicillin in the treatment of a large variety of infections.

The gain in expectation of life from 1944 to 1945 was not shared equally by the several color and sex groups. Females made a much better showing than males. For example, at age 20, the gain in expectation of life among white females was two thirds of a year and among colored females almost a full year, whereas among males in each color group there was virtually no change. The less favorable record for males was due largely to the high mortality from accidents among men serving in the armed forces. The expectation of life at age 20 in 1945 was: white

TABLE 1—EXPECTATION OF LIFE AT BIRTH. WEEKLY PREMIUM-PAYING BUSINESS. INDUSTRIAL DEPARTMENT, 1879–1889 TO 1945. METROPOLITAN LIFE INSURANCE COMPANY

CALENDAR YEAR	EXPECTATION IN YEARS	CALENDAR YEAR	EXPECTATION IN YEARS	CALENDAR YEAR	EXPECTATION IN YEARS
1945*	64.95	1935	60.25	1925	55.51
1944*	64.40	1934	59.45	1924	55.62
1943*	63.86	1933	59.19	1923	54.55
1942*	64.26	1932	58.80	1922	55.04
1941	63.42	1931	57.90	1921	55.08
1940	62.93	1930	57.36	1919–1920	51.14
1939	62.50	1929	55.78	1911–1912	46.63
1938	61.94	1928	55.88	1879–1889	34.00
1937	60.71	1927	56.42		
1936	60.31	1926	55.02		

Gain, 1945 since 1911–1912, 18.32 years; since 1879–1889, 30.95 years.

*The figures for the years 1942 to 1945 exclude military and civilian deaths from enemy action; they include all other deaths, and in addition, make an allowance for deaths that would normally have occurred among those killed in action.

TABLE 2—EXPECTATION OF LIFE AND MORTALITY RATE* PER 1,000 AT SPECIFIED AGE. BY COLOR AND SEX. WEEKLY PREMIUM-PAYING BUSINESS. INDUSTRIAL DEPARTMENT, 1945. METROPOLITAN LIFE INSURANCE COMPANY

AGE	EXPECTATION OF LIFE					MORTALITY RATE PER 1,000				
	TOTAL PERSONS	WHITE		COLORED		TOTAL PERSONS	WHITE		COLORED	
		Males	Females	Males	Females		Males	Females	Males	Females
5	63.32	60.56	66.46	57.15	60.16	1.20	1.29	1.04	1.35	1.33
10	58.57	55.82	61.69	52.46	55.46	.61	.69	.46	.90	.90
15	53.77	51.03	56.83	47.73	50.79	.90	1.05	.56	1.77	1.97
20	49.08	46.42	52.02	43.35	46.41	2.18	3.14	.93	6.56	3.40
25	44.64	42.17	47.29	39.67	42.23	2.30	3.16	1.31	5.77	3.96
30	40.15	37.77	42.62	35.74	38.05	2.55	3.08	1.66	5.43	4.22
35	35.68	33.33	37.99	31.72	33.85	3.40	3.85	2.23	6.87	5.04
40	31.32	29.02	33.44	27.80	29.78	4.58	5.31	3.04	8.09	7.35
45	27.10	24.89	29.00	23.96	25.96	6.74	8.36	4.66	10.71	10.00
50	23.10	21.04	24.76	20.36	22.30	10.00	12.73	7.35	16.33	13.19
55	19.34	17.49	20.73	17.18	18.86	14.47	19.10	10.59	23.84	18.45
60	15.83	14.28	16.92	14.32	15.70	21.41	28.17	16.45	31.92	25.85
65	12.64	11.42	13.44	11.72	12.85	32.11	41.26	26.26	44.42	36.85
70	9.80	8.91	10.36	9.45	10.36	49.03	60.52	43.14	61.03	52.57
75	7.37	6.80	7.79	7.55	8.23	76.73	91.78	69.70	88.70	73.56

*Exclusive of deaths from enemy action, but with an allowance for deaths that would normally have occurred among those killed by enemy action.

males, 46.42 years; white females, 52.02 years; colored males, 43.35 years; and colored females, 46.41 years. Corresponding figures for other quinquennial ages are shown in the left hand panel of Table 2.

The mortality rates upon which the figures for the expectation of life are based are set forth in the right hand panel of Table 2. White females recorded remarkably low death rates at the younger ages—rates of less than 0.5 per 1,000 at ages 9 to 13, and of less than 1 per 1,000 in the broad age range 6 to 20. White males also had very low mortality rates in childhood, but the effect of the war is reflected in the relatively high figures for men in the draft ages, even when deaths from enemy action are excluded. Thus, we find that at age 20 the ratio of male to female mortality in 1945 was 3⅓, whereas in the prewar year 1940 the ratio was little more than 1⅓.

The mortality among the colored continues to be much less favorable than that for white policyholders, particularly at the ages of adolescence and early maturity. Thus, at age 10, the death rate for colored girls was twice that for white girls; at age 20 the ratio was as high as 3⅔ to 1. Yet great progress has been achieved by this group of policyholders, particularly in recent years.

In reviewing the progress made in extending the average length of life of the industrial population during the war years, one has good reason to feel optimistic with regard to further accomplishment in this direction in the years to come. There can be little doubt that the efforts of medical science and public health administration, which have been so effective in preventing disease and premature death, will continue to produce gratifying results in the future with further extension of life.

The Money Value of a Man

TWENTY years have passed since the discussions began, in the pages of this BULLETIN, on the capitalized value of a productive human life. In the past two decades material changes have taken place in some of the fundamental factors entering into the computation. Years have been added to the average human life and to the productive period of the individual. Rates of interest which, at the last time of writing, seemed appropriate for discounting future earnings, are much too high according to current conditions. A revision of the computation to take care of these changed conditions and at the same time to introduce other desirable modifications has accordingly been in progress and will soon be presented in book form. Here we shall, as on the former occasion, set before the reader a few selected aspects of the subject, referring for further detail and more extended treatment to the forthcoming book.

First, to recall briefly the underlying concepts. It is hardly necessary to repeat that the evaluation

undertaken is definitely restricted in scope. What concerns us here is the value of a wage-earner or salaried person to his family, his dependents, *as a source of income measured in dollars and cents*. That his relation to his family involves sentimental values of high order does not affect our estimates, which are clearly intended to exclude such immeasurable quantities, and to repose solely on the practical if prosaic operation of counting the money in his pay envelope or salary check. Another restriction is that we shall be considering essentially the man's value *to his family*. He may have some other value to his employer, his associates, or the community to which he pays taxes and for which he may perform voluntary services not rewarded in cash. After all, the average man, at any rate, lives primarily for his family, and it is for their protection that the bulk of Life insurance is purchased; for the very purpose of providing against the eventuality that premature death may deprive his dependents of this support, the capitalized value of which is to be determined. It is found to be a very respectable figure even for modest income groups.

With this understanding, the principles of the evaluation are simple enough. For a man of given age, with the prospects of life and death according to an appropriate mortality table, and with a given earning capacity, the present worth of his net future earnings is to be computed—*net* earnings in the sense that from his gross earnings is to be deducted his own cost of living, since only the remainder is of direct benefit to his dependents. In certain special cases there may also be a direct interest in his *gross* future earnings, as for example if he suffers some severe injury which wrecks his earning capacity without terminating his life, so that he not only ceases to support his family, but himself has to be supported by them. In such cases the evaluation of equitable compensation for injuries incurred in the pursuit of gainful occupation is properly made on the basis of gross future earnings.

With computations carried out along the lines indicated, values have been computed for men with various earning capacities. The results in abridged form are exhibited in the accompanying table.

It will be seen that these sums—earnings over four decades or more—are large totals. Even for a modest annual earning of $2,500, the present value of the net future earnings at age 30 amounts to $32,300.

Such figures as these are forceful reminders, where such are needed, for all those whose responsibility it is in one way or another to provide for the eventualities of reduced or entirely abolished earnings of the wage-earner, whether by death or partial or total incapacitation. This responsibility falls first on the head of the family, whom it is well to remind of his capitalized value, the amount of which may come to him as a surprise. It is to protect his wife and family that wisdom directs him to cover through Life insurance, so

PRESENT VALUE OF GROSS AND NET FUTURE EARNINGS FOR MEN OF SPECIFIED AGE AND ANNUAL EARNINGS,* BASED UPON MORTALITY OF WHITE MALES IN THE UNITED STATES, 1939–1941, AND INTEREST AT 2½ PERCENT

AGE	ANNUAL EARNINGS* AT SPECIFIED AGE					
	$2,500	$3,500	$5,000	$2,500	$3,500	$5,000
	Value of *Gross* Future Earnings			Value of *Net* Future Earnings		
30	$50,600	$79,300	†	$32,300	$53,200	†
35	43,000	63,600	†	26,600	40,600	†
40	36,600	54,000	$83,300	21,300	32,300	$54,500
45	30,700	45,700	69,100	16,000	24,700	41,900
50	24,800	37,400	55,500	11,000	17,300	30,100
55	18,900	28,500	41,900	6,100	10,000	18,700

*After deduction of income tax.

†Earnings of $5,000 per annum, at the ages specified, would indicate ultimate earnings above $10,000 per annum. The collection of estimates of which an excerpt is here presented, does not extend to these higher earning brackets.

far as his means permit, the risk of interruption or termination of his earning capacity.

As already indicated, occasions arise not infrequently in business enterprises where protection against loss, for instance by the incapacitation of one's partner, indicates the desirability of Life insurance coverage.

Even more important in a sense, because dealing with very much larger sums, is the application of these concepts to public health administration. Those in charge may be encouraged in their efforts to secure the necessary funds by the knowledge that public health can be purchased, and that part of the price of the purchase is returned to the community by reduced expenses for sickness and for the support of indigent widows and orphans.

To take another instance, it is heartening to think that persons handicapped, whether at birth or through accident in later life, with infirmities that would ordinarily reduce their earnings, can often have their capacity enhanced, or restored in whole or in part, by such care as is best furnished by public organizations and private philanthropy.

The benefits derived by such rehabilitation and by special measures to find the most suitable work for those partially incapacitated are not fully appreciated until one reflects on the large sums of money involved. This is true not only for the individual, but even more so for the community, which at all times, but more than ever now in the post-war period, includes a large number of such handicapped persons.

Encouraging Trends in Heart Disease

MEASURED in terms of sheer numbers of persons affected, heart disease is our most important medical and public health problem. There are today about four million people in the United States who have some form of heart disease, and the number of cases is steadily increasing. Heart disease ranks first in the list of causes of death. It is not surprising, therefore, that there is a widespread impression that the situation with regard to the disease is critical, that the outlook for the patient with heart disease is poor, and that the conditions of modern life are largely to blame. Actually, the situation is much better than appears on the surface, and these current gloomy beliefs about the disease are not warranted by the facts.

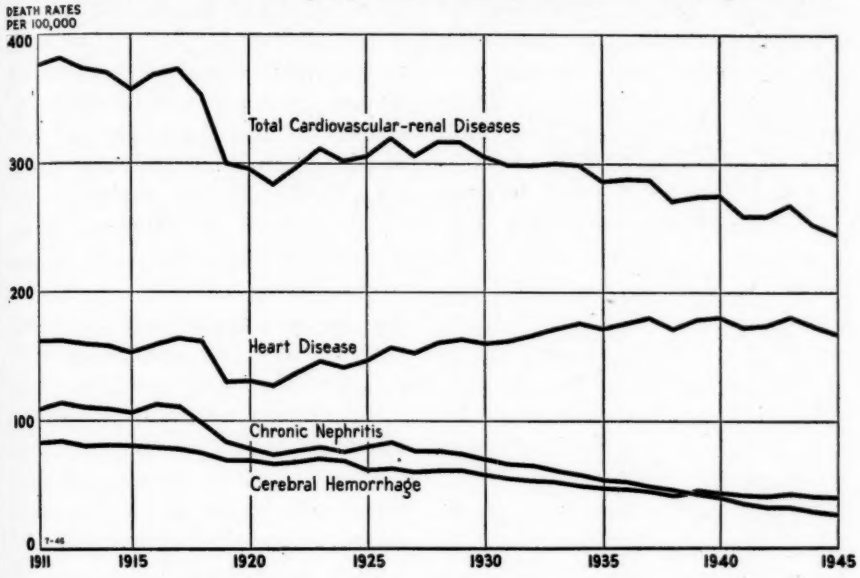
It is true that the crude death rate from heart disease has shown a steady increase over the years. The major part of this increase, however, simply reflects the rapidly increasing proportion of older persons in our population. In the past 17 years, among the millions of persons insured in the Metropolitan's Industrial Department, there has been an almost uninterrupted rise in the crude death rate from the disease, reaching a maximum in 1943, with a total increase of nearly 60 percent since 1928. As against this large increase, the rate corrected for changes in the age, sex, and color composition of the insured shows a rise of only 12 percent from 1928 to the maximum in 1943, and the 1945 rate is only 4 percent above that for the year 1928.

Aside from the aging of the population, there are other factors of importance that have brought about an increase in the *recorded* death rate from heart disease. Unfortunately, it is not possible to "correct" the rate to allow for their effect. Increasingly many deaths formerly reported as from nephritis or from cerebral hemorrhage, have been more recently ascribed to heart disease because of the changing medical concept regarding the relationship of high blood pressure to these conditions. For, the present concept is that the heart in most such cases is the organ primarily affected by increased blood pressure. Also, as a result of the more accurate determination of the cause of edema (dropsy), a frequent late complication in both heart and kidney disease, many cases with dropsy are now recognized as due to heart failure which formerly would have been ascribed to renal disease.

The effect of these changing diagnostic concepts is seen in the chart on page 7. This shows a steady and marked reduction in the death rate from chronic nephritis among Industrial policyholders of the Company, and also a smaller, though unmistakable, reduction in the death rate from cerebral hemorrhage. While there probably has been an actual decline in the death rate from both these conditions, and more particularly from chronic nephritis, the

AGE-ADJUSTED DEATH RATES PER 100,000 FROM TOTAL AND SEPARATE CHRONIC CARDIOVASCULAR-RENAL DISEASES

Metropolitan Life Insurance Company, Industrial Policyholders, 1911-1945, Ages 1 to 74



major part of the reduction represents merely the shifting pattern in the diagnosis of cardiovascular-renal diseases which now emphasizes cardiac damage rather than nephritis and cerebral hemorrhage.

When all of these influences are taken into account, it is doubtful whether there has been any real increase whatever in heart disease, beyond what is expected from the increase in the number of older persons in our population. Indeed, it is likely that there has been an actual *decrease* in the mortality from heart disease at every age, roughly parallel to the decline in the death rate, exhibited in the top line of the chart, for the aggregate of the cardiovascular-renal diseases. As was shown in a recent issue of the STATISTICAL BULLETIN,* the rates for this group as a whole have declined even in the older age groups.

Without any allowance for the factors indicated above, there has been a definite reduction in heart disease mortality up to age 45. At ages 1 to 24 years, this death rate in recent years among the insured white males has fallen about 60 percent as compared with 1911–1915. Among young white females the reduction is even larger. At ages 25 to 44 also their death rates have in recent years been lower than at any time since 1911. Among white males 25 to 44 years old, the death

*Large Decline in Mortality from Degenerative Diseases. STATISTICAL BULLETIN, March 1946, page 5.

rate has been stable for 10 years, but the recent level of the rate is well below that for 1911–1915. These declines at ages under 45 are due chiefly to the decline in the mortality from rheumatic heart disease.

As regards the diseases of the coronary arteries, which account now for a large proportion of deaths ascribed to heart disease, the rapid increase in the mortality from these conditions represents almost entirely the changing diagnostic concepts in heart disease that are reflected in medical terminology. It is noteworthy that, as the mortality from coronary thrombosis and occlusion has gone up, the death rate from myocardial diseases has fallen.

The outlook in various types of heart disease has been shown in recent studies by the Company and by a number of physicians to be much better than has previously been realized. It is found, for example, that a considerable proportion of patients who have suffered an attack of coronary occlusion are still living 10 years after the initial attack, and that many of these people are restored to full or partial working capacity. Similarly, studies of children attacked by rheumatic fever show that more than 90 percent of those who escape serious heart damage lived 10 years or longer, and even among those with heart damage a great majority are living 10 years after onset. Those without serious heart involvement can usually lead normal lives, with little restriction. This applies also, in considerable measure, to those with damaged hearts, although they must avoid certain types of occupations.

Altogether then, there is little cause for alarm over the situation in heart disease today. The great bulk of the deaths from this cause occur in older people. It is necessary, of course, to see that elderly heart disease patients are properly cared for. Relatively few of them, however, require or can afford expensive hospital or institutional care. Many cardiacs in the older age groups can live happy useful lives in their own households. Their social, economic, and cultural problems are often more important than their medical problems. The special types of facilities required to cater to these people are in many instances a responsibility of the community.

Further improvement is possible in the reduction of the ravages of heart disease among younger persons. A major task is the attack on the preventable causes of heart disease, particularly of rheumatic fever in children and of syphilis in young adults. Much can be accomplished also by the early detection of heart disease and the prompt institution of a suitable regimen of medical and nursing supervision. Such steps are necessary not only for heart disease of infectious origin, but for the so-called degenerative types due chiefly to high blood pressure or arteriosclerosis. It is, of course, impossible to prevent these varieties of heart disease entirely, but much can be done in the way of postponing their onset and in slowing down their progress.

Recent Increase in Homicides

HOMICIDES, like suicides, have increased markedly since the close of the war. Among the Industrial policyholders of the Metropolitan Life Insurance Company, each month, beginning with September 1945, has shown a higher homicide rate than the corresponding month of the preceding year. The rate for the first six months of 1946—4.2 per 100,000—was more than one third above the figure of a year ago, and the highest in seven years.

A parallel rise in the homicide death rate is observed in the general population of the United States. The latest official reports, based on a 10 percent sample of the deaths reported in the country, indicate that the homicide death rate for the first five months of 1946 was 5.2 as against 4.0 for the like period of 1945, an increase of nearly one third.

The increase in homicides among the Industrial policyholders has been fairly uniform for the several color and sex groups, except for white females, among whom the homicide mortality is negligible. For the first six months of 1946, the rise from the like period of last year was 36 percent among white males, 33 percent among colored males, and 37 percent among colored females. When the data are examined by age, however, very considerable differences, and even contrasting trends, are observed. At the age periods under 45 years large increases in the homicide death rate are in evidence, whereas at ages 45 and over, the rates have tended to decrease. The death rates by age for each color and sex group are shown in the table on page 10.

What explanation is there for the immediate postwar increase in homicides? In the official figures for the general population of the United States, a part of the rise may well be attributed to the inclusion, in the records of the Bureau of the Census for 1946, of large numbers of returned veterans who, during the war years, were abroad, and hence not included in the official statistics for the United States population. These men are precisely in the age groups which normally contribute a large proportion of both the culprits and the victims of homicide. Obviously, however, this is not the entire explanation, for the mortality records of the Metropolitan Industrial policyholders, which *include* the men in service overseas, show the same trend. It seems likely, therefore, that there are some further factors operating. Among these may be the postwar letdown in national morale, particularly a natural unrest among discharged servicemen who, having completed a strenuous assignment under strict supervision, are suddenly left on their own resources and responsibility. Moreover, postwar job opportunities may have failed, in many instances, to come up to expectations. In addition, there is a wartime acquired familiarity with firearms and an unusual number of these, largely trophies or "souvenirs" from the war, are available.

DEATH RATES PER 100,000 FROM HOMICIDES—ALL FORMS. BY COLOR, SEX, AND AGE PERIODS. FIRST SIX MONTHS OF 1946 AND 1945. METROPOLITAN LIFE INSURANCE COMPANY, WEEKLY PREMIUM-PAYING INDUSTRIAL BUSINESS

AGE PERIOD YEARS	DEATH RATES PER 100,000 (ANNUAL BASIS)							
	WHITE MALES		WHITE FEMALES		COLORED MALES		COLORED FEMALES	
	1946	1945	1946	1945	1946	1945	1946	1945
0 to 74*	3.0	2.2	.8	.7	27.6	20.8	7.8	5.7
0 to 14	.2	.4	.1	.2	2.0	1.0	—	1.0
15 to 19	3.9	1.0	.5	.5	36.2	15.4	10.9	4.1
20 to 24	3.1	1.9	1.4	1.1	43.6	26.8	12.4	11.2
25 to 34	6.4	3.5	1.0	1.2	48.9	43.6	18.6	15.1
35 to 44	6.4	5.1	1.4	.8	57.5	30.5	14.6	8.2
45 to 74	2.3	3.3	1.1	1.1	22.6	30.0	4.3	2.8

Note: Rates for 1946 are provisional.

*Standardized for age on basis of the Standard Million of England and Wales, 1901.

Another possible factor, affecting more particularly the civilian population, may have been the postwar cutback in industrial employment and the discontinuance of civilian war activities. As a result of these developments, presumably people have had more time for petty quarrels and domestic disputes, which are the immediate cause of a large proportion of homicides.

There is no way of knowing whether the recent increase in homicide is only temporary or whether it will continue for some time. The experience for World War I does not furnish any clue. The annual death rates for many years both before and after the close of that war fluctuated within narrow limits without any definite upward or downward trend.

Homicide is an important social problem. Even in 1944, when the mortality from this cause dropped to the lowest point on record, there were still more than 6,500 deaths in the general population of the United States. There is no simple solution to this complex problem. Further restricting the sale of firearms would undoubtedly have a salutary effect. More generally, greater efforts should be made to eliminate such environmental factors as poor housing, ignorance, and the lack of proper recreational facilities, conditions that encourage crime and antisocial behavior.

Comparative Data on the Causes of Death Among Industrial Policyholders

The following table shows the mortality among Industrial policyholders for July 1946 and July 1945, together with the death rates for the first seven months of 1946, 1945, and 1944.

DEATH RATES* PER 100,000 POLICYHOLDERS FROM SELECTED CAUSES
WEEKLY PREMIUM-PAYING INDUSTRIAL BUSINESS
METROPOLITAN LIFE INSURANCE COMPANY

CAUSE OF DEATH	ANNUAL RATE PER 100,000 POLICYHOLDERS*				
	July 1946	July 1945	Year to Date: End of July		
			1946	1945	1944
ALL CAUSES—TOTAL	687.6	792.8	793.2	890.4	838.7
—Excluding war deaths	*682.8*	*705.6*	*774.0*	*767.3*	*806.0*
Typhoid fever	0.4	0.3	0.2	0.3	0.2
Measles	.6	.4	.9	.2	1.2
Scarlet fever	.1	.1	.2	.3	.5
Whooping cough	.4	.7	.7	.8	.5
Diphtheria	.4	1.2	.6	.8	.6
Influenza	1.1	1.6	6.5	3.9	12.9
Pneumonia (all forms)	19.4	20.1	30.5	31.3	41.0
Tuberculosis (all forms)	35.9	35.6	39.0	38.3	42.6
Tuberculosis of respiratory system	32.4	32.2	35.3	34.6	38.7
Syphilis	7.9	7.7	8.5	8.7	9.7
Cancer (all forms)	114.1	108.6	115.1	112.8	109.1
Diabetes mellitus	21.2	24.1	28.1	26.3	29.9
Cerebral hemorrhage	63.0	65.1	70.8	69.2	69.4
Diseases of the coronary arteries and angina pectoris	63.2	60.6	72.9	68.7	65.6
Other chronic heart diseases†	136.8	140.6	173.5	166.1	178.0
Diarrhea and enteritis	2.4	3.2	2.6	3.1	3.6
Appendicitis	4.1	4.8	3.6	4.9	5.4
Chronic nephritis	38.5	38.3	44.8	46.5	49.6
Puerperal state—total	2.8	3.8	3.0	3.6	4.3
Suicides	6.2	5.9	7.4	6.1	6.2
Homicides	2.8	2.8	4.0	3.1	2.8
Accidents—total	51.9	61.2	49.5	55.7	54.0
Home accidents	8.8	6.7	11.2	10.6	11.3
Occupational accidents	4.7	4.7	4.7	5.1	5.6
Motor vehicle accidents	14.7	14.1	15.6	12.9	13.7
War deaths (enemy action)	4.8	87.2	19.2	123.1	32.7
All other causes of death	109.7	118.9	111.7	116.8	118.6

*The rates for 1946 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†International List (1940) titles 92, 93 (c), (d), (e), and 95.

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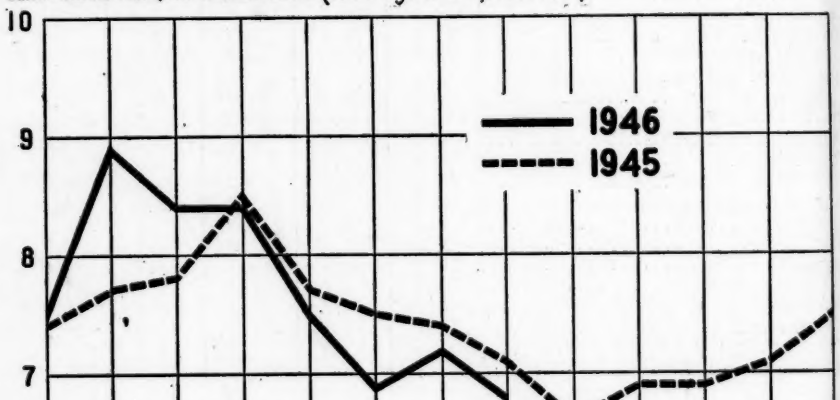
MORTALITY FROM ALL CAUSES

METROPOLITAN LIFE INSURANCE COMPANY
INDUSTRIAL DEPARTMENT, WEEKLY PREMIUM-PAYING BUSINESS

DEATH RATES PER 1,000 ANNUAL BASIS (*1946 figures are provisional*)



(DEC)	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1945	7.7	7.8	8.5	7.7	7.5	7.4	7.1	6.6	6.9	6.9	7.1	7.5
1946	8.9	8.4	8.4	7.5	6.9	7.2	6.8					

* *Does not include war deaths*

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